Stanford Sierra Camp
Medical Information for Minors,
Consent for Emergency Medical Treatment &
Emergency Contact Information Form

Reservation Holder's Name: _____Week_____

Minor Participant Name: _____ Date of Birth _____

Minor Participant Name: _____ Date of Birth _____

Minor Participant Name: _____ Date of Birth _____

Minor Participant Name: _____ Date of Birth _____

Medical Insurance
Is the participant(s) covered by medical/hospital insurance? ☐ Yes ☐ No
If so, list the policy/group number: _____
Carrier Name _____
Name of Insured _____
Relationship of Insured to Participant(s): _____

Medical Information
Primary Care Physician _____
Phone _____
Address _____
City, State and Zip Code _____

Additional Medical Information: *Please clarify which participant each condition pertains to.*

Do any of the participants have any chronic or acute medical conditions that would require any accommodation to permit participation in the program/activity? ☐ Yes ☐ No
If yes, please explain.

Please list any medications that would need to be administered to participant(s) in case of an emergency.

Please list any allergies to medications, food, pollen, insect bites, etc. and/or other dietary restrictions, and indicate if participant carries an EpiPen for allergic reactions.

Please list any other special needs or medical issues that would be important for caregivers to know about in case of an emergency.

In Case of Emergency, Please Notify

Primary Contact's Name _____
Primary Contact's Camp Cabin Name _____
City _____
Relationship ☐Parent ☐Legal Guardian ☐Sibling ☐Other, describe _____
Home Phone _____ Alternate Phone _____
Email Address _____

AND/OR

Secondary Contact's Name _____
Secondary Contact should not be at Stanford Camp
City _____
Relationship ☐Parent ☐Legal Guardian ☐Sibling ☐Other, describe _____
Home Phone _____ Alternate Phone _____
Email Address _____

Consent for Emergency Medical Treatment

I/We, the undersigned, parent(s)/guardian(s) of _____ , _____ , _____ , _____ a minor, do hereby authorize SAA Sierra Programs LLC (Stanford Sierra Camp & Conference Center) as agents for the undersigned, to consent to an X-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of a licensed physician.

It is understood that this authorization is given in advance of any specific diagnosis treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforesaid physician in the exercise of his or her best judgment may deem advisable.

I understand that as a parent/legal guardian, I will be responsible for the cost of any service or treatment provided at the consent of SAA Sierra Programs LLC.

I hereby give consent to SAA Sierra Programs LLC to obtain all emergency medical care under whatever conditions are necessary to preserve the life, limb or wellbeing of the Participant named above.

This authorization shall be valid and effective from _____, 2022 until _____, 2022 unless revoked sooner in writing delivered to SAA Sierra Programs LLC.

Parent/Legal Guardian Signature
(If parent/guardian's plan covers the participant or if participant is under 18 years old at the start of the program/activity)

Signature _____ Date _____

Parent/Guardian Name Printed _____